SECTION 2

Home and Community-Based Waiver Services for Individuals with Physical Disabilities

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1 GENERAL POLICY

On June 1, 1998, the Health Care Financing Administration granted statutory waivers to the State of Utah in order for the State to offer a unique array of Medicaid-covered home and community-based services to a limited number of eligible, physically disabled adults as an alternative to Nursing Facility care.

Waiver of Comparability

Services described in Chapter 3 of this manual are available to *only a limited number* of eligible individuals. In accordance with regulations found at Section 1915(c) of the Social Security Act, "waiver services" need not be comparable in amount, duration or scope, to services covered under the Medicaid State Plan.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements, the State uses more liberal income calculations when determining a waiver applicant's / recipient's Medicaid eligibility. Waiver recipients are permitted to retain more of their monthly income for personal needs than NF recipients in order to compensate for the higher costs associated with living in the community.

1 - 1 Acronyms and Definitions

For purposes of the Home and Community-Based Waiver for Individuals with Physical Disabilities, the following acronyms and definitions apply:

DSPD Division of Services for People with Disabilities

DOH/LOC/RN Department of Health Level-of-Care Registered Nurse

HCFA Health Care Financing Administration

NF Nursing Facility

PAS Personal Assistance Services

Applicant: an individual who has requested a determination of his/her eligibility for services under the home and community-based waiver program.

Assessment: an examination of an individual who has been determined (through evaluation) to meet the targeted NF level-of-care requirements for participation in this waiver, to determine what waiver services are needed to prevent institutionalization or whether waiver services constitute an acceptable alternative to institutional care.

DOH/LOC/RN: The nurse in the Department of Health who determines NF level of care for waiver applicants/recipients.

Evaluation: the review of an applicant's / recipient's condition to determine whether he/she requires the level of care provided in a Medicaid certified NF, and therefore whether he/she may participate in the waiver.

Health Care Financing Administration (HCFA): the federal agency under the Department of Health and Human Services which is responsible for administering the Medicaid program.

Plan of Care: a written *plan of care* developed by a qualified support coordinator for each individual receiving services under the waiver.

Physical Disability: a medically determinable physical impairment which the physician expects will last for a continuous period of not less than twelve months and which has resulted in the individual's functional loss of two or more limbs to the extent that assistance of another trained person(s) is required in order to accomplish activities of daily living/ instrumental activities of daily living.

Recipient: an individual with a physical disability who meets both the Medicaid and the waiver eligibility requirements and is receiving services under the home and community-based waiver program.

Waiver or Waiver Services: the Home and Community-Based Waiver for Individuals with Physical Disabilities and services provided in accordance with the waiver.

Waiver Support Coordinator: a Registered Nurse employed by DSPD whose responsibilities include overseeing the day-to-day operations of the waiver and assuring that recipients obtain and maintain waiver and other Medicaid services as necessary to ensure their health and welfare and to prevent institutionalization.

1 - 2 Qualified Providers

A. Home and community-based waiver services for recipients with physical disabilities are covered benefits only when delivered by or through providers who have a signed Provider Agreement with DSPD and the Medicaid agency to provide such services.

B. Agencies and individuals providing home and community-based waiver services must meet the applicable licensure, certification and other standards as described in the approved waiver.

C. Individuals providing home and community-based waiver services are subject to all state laws and regulations related to the performance of their duties.

1 - 3 Service Standards

In addition to service standards and limitations described in this manual, home and community-based waiver providers will be held accountable to the standards and policies contained in:

A. their provider contracts with the Division of Services for People with Disabilities, Utah Department of Human Services, if any; and

B. the *Policy Manual of the Division of Services for People with Disabilities* as applicable to the home and community-based waiver.

2 SERVICE AVAILABILITY

A. Home and community-based waiver services, as applied to this waiver, are covered benefits only when provided:

1. to an eligible recipient;

2. by or through a qualified, enrolled Medicaid provider (as described in Chapter 1 - 2, *Qualified Providers*); and

3. pursuant to a written plan of care.

B. The home and community-based waiver serves individuals residing throughout the State.

C. To be eligible for waiver admission and continued enrollment, an individual must meet **all** of the following criteria:

1. be 18 years of age or older;

2. qualify for Medicaid based on his/her income and resources;

3. meet admission criteria for NF care as determined by the DOH/LOC/RN;

4. have at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual;

5. be medically stable, have a physical disability and require in accordance with his/her physician's written documentation, at least 14 hours per week of personal assistance services in order to remain in the community and prevent unwanted institutionalization. For purposes of this waiver, the individual's qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician expects will last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs, to the extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living / instrumental activities of daily living;

6. be capable, as certified by his/her physician within the last two years, of selecting, training and supervising his/her personal attendant(s); and

7. be capable of managing his/her own financial and legal affairs.

WAIVER CONTINUED ENROLLMENT CRITERIA:
A recipient's eligibility for benefits and services under this waiver may continue as long as the individual meets the criteria for Nursing Facility level of care, the specific targeting criteria for the waiver and Medicaid financial eligibility, and can be adequately and safely maintained in the community.

2 - 1 Eligible Applicants

A. Home and community-based waiver services are covered benefits only *for a limited number of Medicaid eligible applicants* who, but for the provision of such services, would require the level of care provided in a Medicaid certified NF, the cost of which would be reimbursed under the Medicaid State Plan.

B. Only the DOH/LOC/RN may determine (and periodically redetermine) an applicant's eligibility for home and community-based waiver services.

C. Once determined eligible, each applicant must be offered an informed choice of receiving either NF or home and community-based waiver services.

D. Inpatients of hospitals, NFs, or ICFs/MR are not eligible to receive home and community-based waiver services (except as specifically permitted for waiver support coordination discharge planning).

2 - 2 Access to Services

The Division of Services for People with Disabilities (DSPD) is the only enrolled provider of waiver support coordination services for this waiver and is the first point of contact for access to waiver services. Prior to admitting an applicant to the home and community-based waiver, a DSPD qualified waiver support coordinator must do all of the following:

A. obtain required and other necessary evaluations and thoroughly assess the applicant's needs and condition;

B. determine whether the applicant qualifies for Medicaid-reimbursed NF care and services;

C. determine whether feasible alternatives are available in the community;

D. ensure the applicant is Medicaid eligible by completing the 927 form and submitting to the eligibility worker;

E. offer the applicant an informed choice of waiver services or NF services.

2 - 3 Assessment

An assessment provides information for the qualified waiver support coordinator to determine whether waiver services constitute an acceptable alternative to NF care and, if so, which waiver and other services are needed to maintain the applicant in the community. The waiver support coordinator consults with physicians and other health professionals as necessary to thoroughly evaluate an applicant's clinical condition. Through the assessment process, a support coordinator obtains the required diagnostic documentation.

A waiver support coordinator reviews the required and other necessary documentation to ascertain the applicant's medical, social, and functioning levels. Only after such a review will the support coordinator be presumed to have sufficient information to determine whether an applicant's condition and needs meet the waiver admission eligibility criteria.

2 - 4 Level-of-Care Evaluation

Level-of-care evaluations (and periodic reevaluations) are conducted by and through the DOH/LOC/RN.

A. The DOH/LOC/RN will certify that an applicant meets the home and community-based waiver level-of-care requirements only when the applicant meets the following conditions:

   1. Requires care above level of room and board as documented by at least two of the following criteria:

      a. Due to diagnosed medical conditions, the individual requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

      b. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires NF care; or

      c. The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less-structured setting and alternatives have been explored and are not feasible.

   2. **Plus** must meet all of the following:

      a. has an appropriately documented diagnosis of physical disability as defined in Chapter 1 - 1, *Acronyms and Definitions;*

      b. has needs which can adequately and appropriately be met in the home and/or community; and

      c. there is reasonable indication that the applicant might need NF services in the near future (that is, a month or less) unless he/she is provided home and community-based waiver services.

B. The eligible applicant's level of care is certified by the support coordinator and the DOH/LOC/RN on the Assessment of Medical Necessity for Long Term Care form.

2 - 5 Required Documentation for Level-of-Care Evaluation

At a minimum, the following documentation must be obtained and included in an applicant's or recipient's file to support a waiver level-of-care determination:

A. documentation of a physical disability signed by a licensed physician;

B. an assessment of medical necessity for long term care, indicating total points of 22 or above, completed by the R.N. support coordinator and determined as meeting NF level of care by the DOH/LOC/RN;

C. certification by physician that recipient is capable of selecting, training, and supervising his/her personal attendant(s), and managing his/her financial and legal affairs.

2 - 6 Recipient Freedom of Choice

A. When an applicant is initially determined eligible for waiver services, the applicant will be informed of the alternatives available under the waiver. If there is a waiting list for admission to the waiver, the waiver support coordinator will inform the applicant about the DSPD's waiting list procedures and selection criteria. Refer to Chapter 2 - 7, *Waiting List*.

B. Once informed of the feasible alternatives under the waiver, the eligible applicant or legal representative will be offered the choice of institutional (NF) or home and community-based services. The applicant's choice is documented on the Consent Form.

C. An applicant will not be offered waiver services if the assessment indicates he or she cannot be adequately served in the community.

D. The waiver support coordinator will offer the choice of waiver services only when two conditions are met:

1. the applicant's needs can be met appropriately in the community with waiver services; and

2. all parties have agreed to the plan of care. Refer to Chapter 2 - 8, *Plan of Care*.

E. If waiver services are chosen, the applicant will also be given the opportunity to choose the providers of waivered services if more than one qualified provider is available. The applicant's choices of services and providers are documented in the plan of care.

F. Once the applicant has chosen home and community-based waiver services and the choice has been documented by the waiver support coordinator, annual re-documentation of choice is not required. However, a recipient has the option to choose institutional (NF) care at any time he or she is receiving waiver services.

2 - 7 Waiting List

In accordance with Utah's approved home and community-based services waiver, the State may serve only a limited number of recipients during each waiver year. For purposes of this waiver, a "waiver year" is the State of Utah fiscal year (July 1 of one year through June 30 of the following year).

When the number of recipients served during the waiver year reaches the number approved by HCFA, a waiting list will be established. When vacancies occur, the support coordinator will, in accordance with waiting list policy and procedures, determine the next enrollee in the waiver program.

2 - 8 Plan of Care

The plan of care is the fundamental tool by which the State ensures the health and safety of recipients. The plan of care constitutes a plan for services, supports, and life activities determined necessary to meet the needs of the applicant or recipient and to prevent institutionalization. It describes all of the services the recipient needs, including waiver services and non-waiver services.

A. Prior to the delivery of waiver services, there must be a completed plan of care in the support coordination record of each applicant.

B. The plan of care must describe, at a minimum, the type, amount, frequency and duration of services to be furnished to the recipient and the type of providers who will furnish them. The plan of care must include the following elements:

- effective date;
- name and address of applicant;
- waiver support coordinator's name;
- all waiver and non-waiver services needed by the applicant, regardless of the funding source, support coordination in all cases;
- documentation of applicant's choice of waiver services and waiver providers, and that the applicant was advised of hearing rights if not provided choice;
- documentation that applicant was informed of the rights in accordance with Division of Services for People with Disabilities policies per R539-2-1 and R539-2-5 and rights to hearing;
- expected start date, amount, frequency and duration of each service;
- the type of provider who will furnish each service; and
- applicant's waiver support coordinator's signature and the date he/she signed the plan.

C. The plan of care is developed by the waiver support coordinator in consultation with the applicant and others as necessary and appropriate.

D. The waiver support coordinator is responsible for ensuring the client receives the services identified in the plan of care.

2 - 9 Periodic Review of the Plan of Care

A. The waiver support coordinator is responsible for ensuring that the plan of care is reviewed and updated as necessary to:

1. note the recipient's progress (or lack of progress);

2. determine the continued appropriateness and adequacy of the recipient's services; and

3. ensure that the services identified in the plan of care are in fact being delivered and are consistent with the nature and severity of the recipient's disability.

B. The plan of care is updated or revised as necessary by the waiver support coordinator in consultation with the recipient. A formal review of the plan of care must be done at least annually within the calendar month in which it is due.

C. A comprehensive reassessment of the recipient by the waiver support coordinator must be conducted in order to determine if the recipient continues to be eligible for the waiver.

2 - 10 Periodic Review of the Level of Care

A. A review of each recipient's level of care must also occur at least annually within the calendar month in which it is due.

B. In order to recertify a recipient's eligibility, the DOH/LOC/RN must find that the recipient continues to meet the NF level-of-care criteria and the recipient's needs are met, and can continue to be met, in the community with available waiver and non-waiver services.

C. Should the recipient experience a significant change in his/her health status, the waiver support coordinator will initiate a reevaluation by the DOH/LOC/RN of the recipient's level of care to assure adequate health and welfare safeguards remain in effect,

The reevaluation will be completed in a time frame consistent with the nature of the change in status, but in no case will the time frame exceed 14 days of the date the waiver support coordinator was notified of the change in status.

D. Recipients found ineligible for continued waiver services will receive notice of hearing rights in accordance with Chapter 2 - 12, *Fair Hearings*.

2 - 11 Termination or Reduction of Home and Community-Based Waiver Services

A. The waiver support coordinator will provide a written notice to a recipient upon termination or reduction of home and community-based waiver services. The recipient will also receive a notice of the right to appeal such decisions.

B. Waiver services may be terminated or reduced for the following reasons:

1. death of the recipient;
2. whereabouts of the recipient unknown;
3. recipient no longer meets the level-of-care requirements;
4. recipient moves out of the state of Utah;
5. recipient voluntarily withdraws from the waiver program;
6. home and community-based waiver services are no longer a feasible option;

7. recipient is no longer eligible for Medicaid;

8. a change in health or functional status of the recipient; or

9. recipient is placed in an institution.

2 - 12 Fair Hearings

A. The Utah Department of Health will provide an opportunity for a fair hearing to applicants or recipients for any of the following reasons:

1. denied eligibility for waiver services;

2. determined eligible for waiver services but not offered the choice of home and community-based waiver services as an alternative to NF services; or

3. denied access to an available service or provider of their choice.

B. Agency Responsibility for Fair Hearings

1. Department of Human Services, Division of Services for People With Disabilities:

a. An applicant or recipient will receive written Notice of Decision (Utah Department of Human Services Form 522) from the waiver support coordinator if he or she is found ineligible for, denied access to, or experiences a reduction in waiver services.

b. The notice will inform the applicant/recipient of his or her right to request a hearing in accordance with the Department of Human Services administrative hearing procedures. Requests for hearings (Form 490) are sent to the Department of Human Services, Office of Administrative Hearings, and that office is responsible for notifying the Department of Health, Division of Health Care Financing (the Medicaid agency).

2. Department of Health, Division of Health Care Financing:

a. The Department of Health will provide an opportunity for a fair hearing to home and community-based recipients who are:

(1) not offered the choice of institutional (NF) services or community-based waiver services;

(2) eligible for but denied the waiver services of their choice; or

(3) denied the waiver provider(s) of their choice if more than one provider is available to render the service(s).

b. It is the policy and preference of the Division of Health Care Financing to resolve disputes at the lowest level through open discussion and negotiation between the Division, applicants/recipients and all other interested parties.

C. The Utah Department of Health provides hearing rights to providers who believe they have been aggrieved by the Utah Department of Health, Division of Health Care Financing, and who submit a written request for a hearing to the agency. Please refer to Utah Department of Health Administrative Hearing Procedures for Medicaid/UMAP Recipients, Applicants, and Providers in SECTION 1, Chapter 6 - 14, *Administrative Review/Fair Hearing*.

3 HOME AND COMMUNITY-BASED WAIVER SERVICES

Home and community-based waiver recipients are eligible to receive regular Medicaid State Plan benefits (i.e., hospital, physician, pharmacy, medical equipment and supplies). In addition, **when necessary to prevent institutionalization and delivered pursuant to a written, signed plan of care, the waiver services listed below are available to recipients:**

- Personal Emergency Response Systems (PERS)
- Personal Assistance Services
- Consumer Preparation Services

Details concerning coverage of these services are contained in the remainder of this chapter.

3 - 1 Personal Emergency Response

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in the event of an emergency. The individual may also wear a portable "help" button to allow for mobility. PERS services are limited to those individuals who live alone, live with others who are not capable of responding in an emergency, or who are alone for significant parts of the day and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision.

By providing immediate access to assistance, PERS serves to prevent institutionalization of those individuals.

3 - 2 Personal Assistance Services

Service consisting of hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care and health maintenance to the extent permitted by State law and certified by the recipient's physician. Housekeeping and chore services and other reasonable and necessary activities which are incidental to the performance of the client-based care may also be furnished as part of this activity. Services will be outlined in the plan of care.

Personal assistance services are provided on a regularly scheduled basis and are available to individuals who live alone, with roommates, a spouse or children. Services may be provided in the recipient's place of residence or in settings outside the place of residence. Services provided and billed to Medicaid as personal assistance are essential to prevent the individual's institutionalization

Qualifications:

Medicaid personal attendants must meet all of the following requirements:

- be at least 18 years of age;
- have a Social Security Number and provide verification of such;
- agree to a Criminal Background Check;

- be registered as a Health Care Assistant with the Division of Occupational and Professional Licensing;
- have the ability to read, understand and carry out written and verbal instructions, write simple clinical notes, and record messages;
- be trained in First Aid;
- be oriented and trained in all aspects of care to be provided to a recipient, including medical care and health maintenance.

All requirements must be met within 60 days after employment.

Personal attendants will be able to demonstrate competency in all areas of assigned responsibility on an ongoing basis. **Providers of personal assistance services will not include a recipient's spouse.** Other family members may provide personal assistance services if and when they meet the provider qualifications.

Supervision:

Supervision of a personal attendant may be furnished directly by the recipient when the safety and efficacy of this supervisory arrangement has been certified in writing by the recipient's physician or otherwise as provided in State law. Documentation of applicable certification will be maintained by the support coordinator and indicated in the recipient's plan of care. If and when it is determined that the recipient is unable to adequately perform such supervisory activities, support will be provided by the waiver support coordinator and other appropriate agencies.

3 - 3 Consumer Preparation Services

Services designed to ensure that waiver recipients are prepared to supervise and direct their personal assistance services. The need for and type of Consumer Preparation Services will vary depending upon the nature of the recipient's disability and his/her experience in directing and supervising personal attendants. Services will be agreed upon by the consumer and the waiver support coordinator and included in the plan of care.

Consumer Preparation Services include:

A. instruction in methods of identifying personal needs and effectively communicating those needs to service providers;

B. instruction in the management of personal attendant(s) including interviewing, selecting, training, scheduling, termination, time sheeting, evaluation of personal attendant performance, backup coverage for personal attendant (e.g., vacation, illness, absence, etc.);

C. instruction in addressing problems such as:

1. changes in level-of-care needs;
2. grievance procedures relating to personal attendant services;
3. personal attendant emergency coverage;
4. exploitation and abuse.

Consumer Preparation Services will not include educational, vocational, or prevocational components.

Qualifications:

- age 18 or older;
- good verbal and writing skills;
- willingness to travel as necessary to training sites;
- one year of working with individuals with severe physical disabilities;
- knowledge of and experience accessing available community resources oriented to the needs of persons with physical disabilities.

4 RECORDKEEPING

A. All individuals and agencies providing Medicaid reimbursed home and community-based waiver services must develop and maintain sufficient written documentation to support the services billed.

B. Sufficient written documentation includes the following:

1. the name of the recipient who received the service(s);
2. the specific reimbursable service provided pursuant to the recipient's plan of care;
3. the date the service was rendered;
4. the amount of time spent delivering the service;
5. periodic updates describing the recipient's response to the service [e.g., progress or the lack of progress]; and
6. the qualified provider/individual who delivered the service.

C. All records must be maintained by the Medicaid provider and made available as requested for State or Federal audit and review purposes.

5 PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Home and Community-based Waiver for Individuals with Physical Disabilities. Coverage is limited to the provider types noted for each procedure code:

78 = licensed child placement agency.

Home and Community-based Waiver Services for Individuals with Physical Disabilities for Category of Service 63

CODE	DHS CODES	DESCRIPTION	*PROVIDER TYPE (s)
Y3080		Personal Attendant Care	78
Y3081		Personal Emergency Response	78
Y3082		Consumer Preparation Services	78

*** Qualified Provider types:**

78 = licensed child placement agency.